BUFFALO LABORERS' WELFARE FUND (the "Fund")

HEALTH REIMBURSEMENT ACCOUNT

PARTICIPANT INFORMATION

Participant's Name (print) _____ SS# **XXX - XX -** _____

Phone Number ( ) _____ Date of birth / / _____

Street Address _____ City _____ State _____ Zip _____

DESCRIPTION OF EXPENSES AND REIMBURSEMENT AMOUNT REQUEST

HEALTH CARE EXPENSES (PLEASE LIST EACH ON A SEPARATE LINE & ATTACH ADDITIONAL SHEET IF NECESSARY)

Patient's Full Name	Relationship	Date(s) of Service	Type of Service	Amount Paid
Total Reimbursement Due:				

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses listed above have been incurred by me and/or my eligible dependents and to the best of my knowledge qualify for reimbursement under the Fund's Summary Plan Description. I have read and understand the preceding sections of this form and I have attached the required supporting documentation. I understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to the above claims. These expenses have not been reimbursed and I will not seek reimbursement under any other health plan, such as an individual policy or my spouse's or dependent's health plan, or any other source. I understand that the expense for which I am reimbursed may not be used to claim any Federal income tax deduction or credit.

Employee Signature_____ Date_____

Employee: Return completed form to the Buffalo Laborers' Welfare Fund at 25 Tyrol Drive, Suite 200, Cheektowaga, NY 14227

BUFFALO LABORERS' WELFARE FUND

IMPORTANT INFORMATION REGARDING REIMBURSEMENTS

HEALTH CARE ELIGIBLE EXPENSES: In general, you may be reimbursed for a health care expense that qualifies as an expense for medical care as defined under Internal Revenue Service Code Section 213(d). This would include, but would not be limited to amounts paid for medical and dental bills, prescription drugs, eyeglasses, and transportation primarily for, and essential to, medical care.

SUPPORTING DOCUMENTATION: The following original supporting documentation must be attached to this form:

Medical/Dental/Vision expenses: Attach original itemized bills that clearly specify the following information

- Date(s) of service or purchase
- Name of the person who received the service, or purchased the item
- Name and address of the provider of the service, or place of purchase
- Amount charged and/or paid
- Type of service/supplies, or items purchased

TIMING: In order to make a claim for a Health Care Account reimbursement benefit, you must submit the claim and all required proof **within 2 years** in which the related expense was incurred.

FRAUDULENT OR INCORRECT INFORMATION:
Your or your Dependent's benefits under the Plan may be denied, suspended or discontinued at any time and for any length of time (including permanently) by duly authorized representatives of the Fund office, the Trustees (or any of their designees) in their sole and absolute discretion if you or your Dependent fail to submit the requested information or proof, make a false statement, or furnish fraudulent or incorrect information (including, for example, submitting fraudulent or altered bills in order to receive reimbursement from the Health Care Account).

The Fund has also adopted a rule that provides that, if a participant or beneficiary makes a false statement or furnishes false or fraudulent information (such as fraudulent or altered bills in order to receive reimbursement for a Health Care Account), at a minimum (in addition to any action taken under the preceding paragraph), the Fund will deduct $500 from the participant's Health Care Account for a first offense and $1,000 for a second offense.